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Evaluating Violence Risk in Young People

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Background

Professionals working with young people often encounter individuals who pose a risk of violence to others. The prevalence of conduct disorder amongst youth is increasing (Maughan, Rowe et al. 2004). The 2005 Young People and Crime Survey estimated 1.8 million violent offenders aged between 10 to 25 in England and Wales. Thirty-eight percent had committed assaults with injury (19% aged 10-17 and 19% aged 18-25) and an estimated 0.5 million were “frequent and serious” offenders (Wilson, Sharp et al. 2006).

Risk evaluation in those under 18 differs in a number of respects when compared to adults. Research based literature in the area is limited, structured tools available are fewer and risks take place on the dynamic background of developmental change (physical, cognitive, social and emotional). Particularly, it is important to take into account aspects of impulsivity, risk taking, forming identity, lack of stability of personality traits and greater peer/social influences during this period. This framework of sensitivity to change is most apparent when looking at risks over time and ways to manage this for young people.

For the purposes of this chapter, violence risk is defined as the likelihood of future physically aggressive behaviour causing harm to others.

Approach

Assessment must ultimately lead to risk management strategies. The current trend is to make structured professional judgements (Borum and Verhaagen 2006). This gives risk assessments, and their context, greater transparency. It also brings the best aspects of clinical and actuarial approaches to risk assessment (Webster, Muller-Isberner et al. 2002). A clinical approach involves making human decisions about risk. In contrast, an actuarial approach considers variables that are utilised to statistically formulate the likelihood of an event occurring.

Any assessment of violence risk needs to consider the nature of the hazard; the likelihood of it occurring; its frequency; duration; potential consequences; immediacy; and relevant contextual and situational aspects (Johnstone, Cooke et al. 2007). These include the identification of any specific triggers and delineating the persons, places and times that are more likely to be associated with increased risk. Static and dynamic risk factors are on a continuum and operate within this structure (see figure 1). Static “historical” risks such as previous behaviour tend not to change and underpin reference to general levels of risk over time. Dynamic (“current”) risk factors are fluid and liable to change. They may be intrinsic, as in disinhibited behaviour through acute mental illness, or extrinsic, as in environmental factors such as a conduct disordered peer group. Violence risk assessment also needs to take into account the presence or absence of protective factors. There are also difficulties

labelling risks as low, medium or high within a given time period unless a relative comparison can be given (Borum and Verhaagen 2006).

Thus, evaluation of violence risk in young people requires a formulation about the likelihood of a specific future risk and in what circumstances and time frame. It provides a structure to assist in identifying how the risk of harm through violence can be prevented, reduced, managed, monitored and evaluated. Hence, risk assessment has moved away from focusing on the individual level of “dangerousness” toward a more specific and contextual framework.

A risk assessment process begins by obtaining relevant information from as wide a variety of sources as is practicable. A direct interview will be generally conducted with the young person. Relevant information would need to be obtained from parents/carers, education, health and Youth Offending Services (YOS). Structured instruments and psychometric assessments provide a useful framework to clinically assist with data collection (see Table 1). Once the information is collated it can be used to generate a specific formulation of risk that still accounts for complexity. As part of this process it is important to assess the extent of the young person’s history of aggressive behaviour, consequences, consideration of risks and protective factors. Professionals should avoid making biased or overconfident judgements. A case example is given in Appendix A.

Protective Factors

Factors associated with a low rate of violent offending include: female gender, high intelligence, engagement in education, well developed social skills, good coping

strategies, non-academic achievement/ hobbies, a non-delinquent peer group and a stable family (Farrington and Loeber 2000; Reese, Vera et al. 2000; Resnick, Ireland et al. 2004). Where a violent offence has occurred the probability of recidivism is reduced by; good engagement with services, reduction in substance misuse, motivation behavioural change, absence of psychopathic traits, victim empathy and remorse, disengagement from delinquent peers and good social support (Carr and Vandiver 2001). Some authors also emphasise protective aspects of strong attachments and resilient personality traits (Borum, Bartel et al. 2003). The circumstances around the offence are important, including the level of provocation, any intoxication, mental illness, evidence of pre-meditation or use of a weapon. Protective factors are not always “healthy”. They can involve inhibitory variables, such as “negative symptoms” in chronic psychosis, a highly introverted personality or withdrawal during depression.

Risk Factors

For both adults and adolescents the most accurate predictor of future violence is previous violence, this risk increasing with each prior episode and especially in the early months following a violent act (White, Moffitt et al. 1990). Early age of aggression is a strong predictor of violence (Borum and Verhaagen 2006). For minors, not all previous aggressive acts will appear on police records as cautions, convictions, warnings or reprimands. This is even less likely if violence is restricted to the family home. The nature and severity of violence, along with understanding the motivation/ intention of a previous violent act is important in considering future risk. The choice of victim is also pertinent, particularly when dealing with sexual offending behaviour. Most forensic clinicians make a distinction between *proactive* or “*instrumental*

violence” (i.e. premeditated and performed for secondary gain) and *reactive* violence which is impulsive and a reaction to real or perceived provocation (Vitaro, Brendgen et al. 2002). The former is more likely to be associated with callous-unemotional personality traits. Indeed, psychopathy is one of the main predictors of recidivist violence (Gretton, Hare et al. 2004). In terms of emerging psychopathy, there is a youth version of the Psychopathy Checklist (Forth, Kossen et al. 2003). Whilst recognising limitations in the reliability of assessing psychopathy before adulthood such tools can assist clinicians including aspects such as a history of cruelty to others (including animals) or during direct interview (when aloofness, superficial charm and/or fluent and plausible lying becomes evident).

There are a number of non-specific associations with violent offending. These include; substance misuse, parental criminality, poor educational attendance, specific learning disorders, delinquent peer group or gang membership, family disruption, socioeconomic disadvantage and urbanicity (Farrington and Loeber 2000). In addition, self-harm, suicide attempts and history of abuse, attention deficit and hyperactivity, impulsivity/risk taking, peer rejection, stress, poor coping, lack of social support, antisocial attitude and family conflict are viewed as psychosocial risk factors (Borum and Verhaagen 2006).

The prevalence of mental health problems in young offenders is high, with often more than one disorder. As Borum & Verhaagen (2006) point out, those offending persistently through their life course tend to have more severe clinical and personality disorders, with higher rates of substance misuse than those offending more specifically during adolescence. Some studies suggest the prevalence for psychotic

disorders for criminally detained juveniles is 1% (Teplin, Abram et al. 2002). This is similar to the general population. However, many young people in detention may experience episodes of psychosis or psychosis-like symptoms that may not fulfil the diagnostic criteria for a severe mental illness. These sometimes occur in the context of depression, personality disturbance, distress or previous trauma. Evaluating adult inpatients with mental disorder, Monahan et al found 18.7 % committed a violent act within 20 weeks of discharge (Monahan, Steadman et al. 2001). In terms of symptoms of mental disorder, a diagnosis of schizophrenia was associated with a lower rate of violence than personality or adjustment disorder. Violence was associated with a co-morbidity of mental disorder with substance abuse, suspicious attitude toward others and voices specifically commanding a violent act. Presence of delusions (type and content) or hallucinations (including command hallucinations) did not relate to future violence. It would be useful for future research to assess whether similar variables have a role for young people with mental disorders. One study of adolescents suggests the best predictors of violence in those with serious mental health problems may be the same as in those without (Clare, Bailey et al. 2000).

There is little empirical evidence to suggest young people along an Autism Spectrum Disorder are more particularly likely to exhibit violent offending behaviour, although milder or atypical presentations of developmental disorders may be over-represented in forensic populations (Siponmaa, Kristiansson et al. 2001). A model of risk assessment in such cases has been proposed (Tiffin, Shah et al. 2007).

Use of Structured Instruments

There are several structured assessment tools designed for use in young people. However, none are currently validated by wide-scale data relating to UK or wider European populations. Table 1 depicts some of the current tools used in connection with violence risk assessment. These include checklists and schedules such as the Structured Assessment of Violence in Youth (SAVRY)(Borum, Bartel et al. 2003) and the Early Assessment Risk List for Boys (EARL-20B)(Augimeri, Koegl et al. 2001) to help guide collation of risk-pertinent information. There are also tools designed to elicit and quantify emerging psychopathic personality traits with the Psychopathy Checklist-Youth Version (PCL-YV)(Forth, Kossen et al. 2003) and Antisocial Process Screening Device (APSD)(Frick and Hare 2001). There is also the development of structured assessments to guide the evaluation of adolescent sex-offenders (Worling and Curwen 2004; Prentky and Righthand unpublished). Schedules to assist in the process of developing a needs-led management plan are useful such as the Youth Level of Service/ Case Management Inventory (YLS/CMI) (Andrews and Hoge 1999; Hoge and Andrews 2002) and Salford Needs Assessment Schedule for Adolescents (SNASA) (Kroll, Woodham et al. 1999). Whilst not specific to young people, the development of tools such as Promoting Risk Intervention by Situational Management (PRISM) (Johnstone, Cooke et al. 2007) 2007), designed for secure mental health inpatient and custodial settings, is useful in looking at preventing and managing risks across the overall system rather than risks in an individual.

Structured clinical assessments that are not “risk-specific” may also feed into risk evaluation and formulation. The evaluation of cognitive functioning may be pertinent if specific or generalised learning disabilities are suspected. More generalised

personality assessment tools such as the Millon Adolescent Clinical Inventory (MACI) may also facilitate a deeper psychological understanding of a young person's needs (Millon, Millon et al. 1993). In addition, if social and communication problems consistent with an Autism Spectrum Disorder (ASD) are evident, specialised assessments can identify factors associated with violent behaviour (Tiffin, Shah et al. 2007).

When using risk-related structured instruments, authors often have unpublished/updated versions and can advise on their application and pre-requisite training. Presently, structured instruments complement but do not replace structured clinical assessment. Moreover, caution needs to be exercised in using tools based on the pre-existing skills and expertise of the administrator and selecting the most appropriate instrument to use with the particular young person. If psychometric assessments are employed in medico-legal settings the limitations of the tool must be qualified.

Conclusions

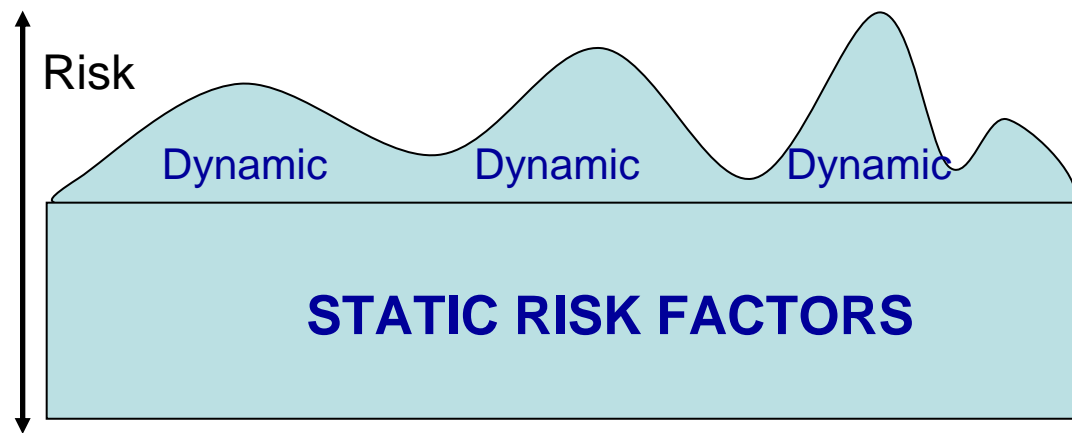
Professionals involved in the care of young people are often required to evaluate, prevent and manage risk. However, there is a lack of research around understanding developmental pathways relating to assessment, prevention and interventions aimed at managing violent risk in young people. Structured instruments and psychometry complement clinical assessment. Within this, it is important to recognise mental health problems in young people exhibiting violence and to take a needs-led approach. Effective information collation, high standard report writing and clear communication of risk are the cornerstones of good clinical practice in this area. A

formulation of risk that recognises complexity, qualifies limitations, yet is specific, enables useful management plans to be made.

Additional Reading

Borum & Verhaagen (2006) provides an excellent resource for current thinking around assessing and managing violence risk in young people. For an overview of risk assessment in children and adolescents; see Tiffin & Kaplan (2004) in relation to mental disorder, Tiffin & Richardson (2006) on the use of structured instruments in violence risk assessment and Cooper & Tiffin (2006) for the evaluation and management of young people displaying psychopathic traits (Cooper and Tiffin 2006; Tiffin and Richardson 2006). Bailey and Dolan have edited a comprehensive text on mental health and offending behaviour in young people (Bailey and Dolan 2004). This book also contains a chapter on needs assessment in adolescents with offending behaviours (Kroll 2004). A more general text on violence in youth is provided by the book "Children who Commit Acts of Serious Interpersonal Violence" (Hagell and Jeyarajah-Dent 2006). Quinsey et al and Pinard & Pagani also provide useful general texts detailing the assessment/management of violence risk (Quinsey, Harris et al. 1998; Pinard and Pagani 2001).

Figure1. The Static-Dynamic Model of Risk



Appendix A: A Case Example

The example outlined below illustrates a formulation of violence risk.

Belinda

“Belinda is a 17 year old female. She has a diagnosis of attention deficit and hyperactivity disorder. She has marked obsessions and rituals. She has an extensive history of violent and non-violent offences from puberty. Her most recent and severe incident of violence involved stabbing a peer whilst intoxicated with alcohol. She is prone to volatile outbursts. She is an endearing and likable character. She has always complied with interventions and, despite having special educational measures, has achieved seven GCSEs. She has never received a custodial sentence. She is currently in a hospital setting with plans to discharge her back home.”

Assessment of risk

- *Information from Belinda, her parents, professionals and case notes.*
- *Analysis of behaviour and functioning within the hospital setting to consider environmental and individual factors impacting Belinda’s outbursts of aggression without the influence of illicit drugs/alcohol.*
- *Objective assessments including the Structured Assessment of Violence Risk in Youth, Millon Adolescent Clinical Inventory, State Trait Anger Inventory and Beck Youth Inventories.*

Formulation of risk

“Belinda is assessed as presenting with a likely risk of future violence to others including the use of a weapon based on one previous violent convictions using a knife, seven previous violent offences and numerous fights over the last five years. Injury involved superficial wounds (static risks). Her risk of being violent is influenced by her tendency to be reactive, blame others and see her violence as justified. Her risk

of violence depends on how well her concentration and impulsivity related to ADHD is managed through medication plus environment and how she is coping with obsessive thoughts and rituals (intrinsic risk factors). Specific contextual factors relating to an increased risk of violence are associating with antisocial peers, access to a weapon, lack of enforcement of boundaries by parents and lack of social consequences through her peers and services making special allowances for her violent behaviour. Violence is most likely to be toward peers or acquaintances, by her or within a group. Intoxication with alcohol/illicit drugs, argument with a peer, disrespectful comment to her or a family member and rejection (particularly by a male peer) attenuates the risk of imminent violence (extrinsic and dynamic risk factors). Belinda's strengths are in her close emotional bond to parents, educational commitment/ability, peer acceptance, compliance with interventions, ability to give up smoking and endearing personality (protective factors)."

Management plan

- *Abstaining from illicit drugs and alcohol, with support from youth drug and alcohol team.*
- *structuring time and peer relationships through college and work experience placement, avoiding 'hanging out' areas, pursuing music interest, peers at home*
- *Compliance with medication related to ADHD and obsessions with psychiatric supervision. Cognitive behavioural intervention to modify her rituals.*
- *Family work to support emotional separation and maintain boundaries*
- *Reinforcement about negative consequences to further violence.*

Table 1. A summary of some existing structured instruments which can contribute to violence risk assessment in children and adolescents

Instrument and Reference	Acronym	Purpose	Structure	Published Validity Data
The Structured Assessment of Violence in Youth (Borum, Bartel et al. 2003)	SAVRY	Guides violence risk assessment in males and females aged 12-18 years	24 items divided into four scales	Yes (Catchpole and Gretton 2003)
The Early Assessment Risk List for Boys (Augimeri, Koegl et al. 2001)	EARL-20B	Guides violence risk assessment in 6-12 year old boys	20 items cover three areas	No
The Early Assessment Risk List for Boys (Levene, Augimeri et al. 2001)	EARL-21G	Guides violence risk assessment in 6-12 year old girls	21 items cover three areas	No
The Checklist for Risk in Childhood (Tiffin and Kaplan 2004)	CRIC	To guide and structure risk assessment in 12-18 year olds seen by mental health services	33 item checklist covering 8 areas	No
The Estimate of Risk of Adolescent Sexual Offense Recidivism (Worling and Curwen 2004)	ERASOR	Assists with estimating the short-term risk of sexual re-offending in 12-18 year olds	25 items covering 5 categories	No
Juvenile Sex Offender Assessment Protocol II (Prentky and Righthand unpublished)	J-SOAP-II	Guides assessment of recidivism risk in adolescent sexual offenders	28 items divided into 4 scales	No
The Youth Level of Service/Case Management Inventory (Andrews and Hoge 1999)	YLS/CMI	Guide to constructing a management plan which will enhance protective factors and reduce risk in adolescents	42 item checklist covering individual, peer and family factors	Yes
The Salford Needs Assessment Schedule for Adolescents (Kroll, Woodham et al. 1999)	SNASA	Assists with constructing a management plan addressing criminogenic and non-criminogenic needs in adolescents	A schedule that covers 21 areas of potential need	Yes
The Psychopathy Checklist- Youth Version (Forth, Kossen et al. 2003)	PCL-YV	The quantification of emerging psychopathic traits in 12-17 year olds	Semi-structured interview schedule, also using collateral information covering 20 domains	Yes
The Antisocial Process Screening Device (Frick and Hare 2001)	APSD	Assists with screening for emerging psychopathic traits In boys aged 6-13 years	20 item questionnaire covering 3 domains of behaviour	No

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